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SENATE BILL 2440 By
Cohen

HOUSE BILL 3213
By Eckles

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, Part 25, to enact the Coverage for Experimental Treatment Act relative to denial of health care coverage.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 25, is amended by adding the following language as a new, appropriately designated section:

Section ___. (a) The title of this act is and may be cited as the "Coverage for Experimental Treatment Act".

(b) As used in this section:

(1) "Enrollee" or "insured" includes a dependent or spouse covered under the plan if such person is the patient for whom coverage has been denied.

(2) "Plan" means and includes any individual, franchise, blanket or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, health maintenance organization or disability insurer that covers hospital, medical or surgical care.

(c) If a plan denies an enrollee's or insured's request for coverage on the grounds that it is experimental or investigational, and the condition for which the treatment is being sought has a high probability of causing death, and the enrollee's or insured's physician recommends the treatment or the enrollee or insured or the enrollee or insured's physician provides the scientific evidence specified in subsection (e), the

plan shall offer the enrollee or insured the opportunity to have the requested service expeditiously reviewed by at least two (2) independent medical experts. These experts shall be physicians or other providers who are specialists in the treatment of the enrollee's or insured's condition and knowledgeable about the treatment recommended for the enrollee or insured. The plan shall not choose or control the choice of the experts, but shall contract with an impartial independent entity to select the experts and arrange for them to give their opinions.

(d) The independent medical experts shall give their professional opinion on whether the requested treatment has reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee or insured who has requested coverage for the treatment under review. Opinions shall be in written form and include, but not be limited to, the following:

(1) A description of the individual enrollee or insured 's condition who has requested coverage for the treatment under review;

(2) A description of indicators relevant to determining whether the requested treatment has reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee or insured who has requested coverage for the treatment under review;

(3) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature; and

(4) A description of such enrollee or insured's suitability to receive treatment according to a treatment protocol in a clinical trial, if applicable.

(e) Scientific evidence shall be deemed sufficient pursuant to subsection (c) if it consists of at least two (2) appropriately designed peer-reviewed published studies by different investigator groups that the treatment is associated with better clinical outcomes than nontreatment or available conventional treatments.

(f) Plans shall provide to the independent medical experts a complete copy of medical record of the enrollee or insured who has requested coverage for the treatment under review. The plan shall notify both the individual enrollee or insured and the treating physician of the enrollee or insured whose treatment is under review of the names of the independent reviewers.

(g) Neither the experts nor the entity arranging for the experts' opinions shall have any professional, familial, or financial affiliation with the plan, except that the plan may pay for the expert opinions. The experts shall have no patient/physician relationship or other affiliation with the specific person whose care is under review. The enrollee or insured shall not be required to pay for independent reviewers' opinions.

(h) The review shall be required to be completed within thirty (30) days of the request, except that if the physician of the enrollee or insured whose treatment is under review states that the requested treatment would be significantly less effective if not promptly initiated, the review shall be completed within five (5) days of the request.

(i) If a majority of the independent reviewers determine that the treatment sought by the enrollee or insured has a reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee or insured who has requested coverage for the treatment under review, then the plan shall authorize and pay for the treatment. If the independent reviewers are evenly divided in their determinations, then the plan shall authorize and pay for the treatment. If less than one-half (1/2) of the independent reviewers determine that the treatment sought by the enrollee or insured has a reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee or insured who has requested coverage for the treatment under review, then the plan may continue to decline authorization and payment for that treatment.

(j) In any court action based on a denial of coverage, compliance with the review process set forth in this section shall create a rebuttable presumption that a coverage determination made pursuant to the review process was reasonable.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.